CHANGING Maryland *for the Better*

Medicaid Community Options

Course 9: Submitting a Plan of Service

Nancy Tyler
Department of Health and Mental Hygiene

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What Types of Plans of Service are There?

- Provisional
  - For new people to the program.
  - Allows for certain services to be approved before finalizing provider enrollment.
    - Very helpful for nursing facility applicants.
  - Provisional approval does not mean services can start.
- Initial
  - Initial plan approval must be made before enrollment.
  - All providers on plan must be final.
- Annual
  - Each year by the medical/technical date, an annual plan must be completed.
  - Same process and rules as an Initial.
- Revised
  - Mid-year changes to an initial or annual.
  - May be done at any time.

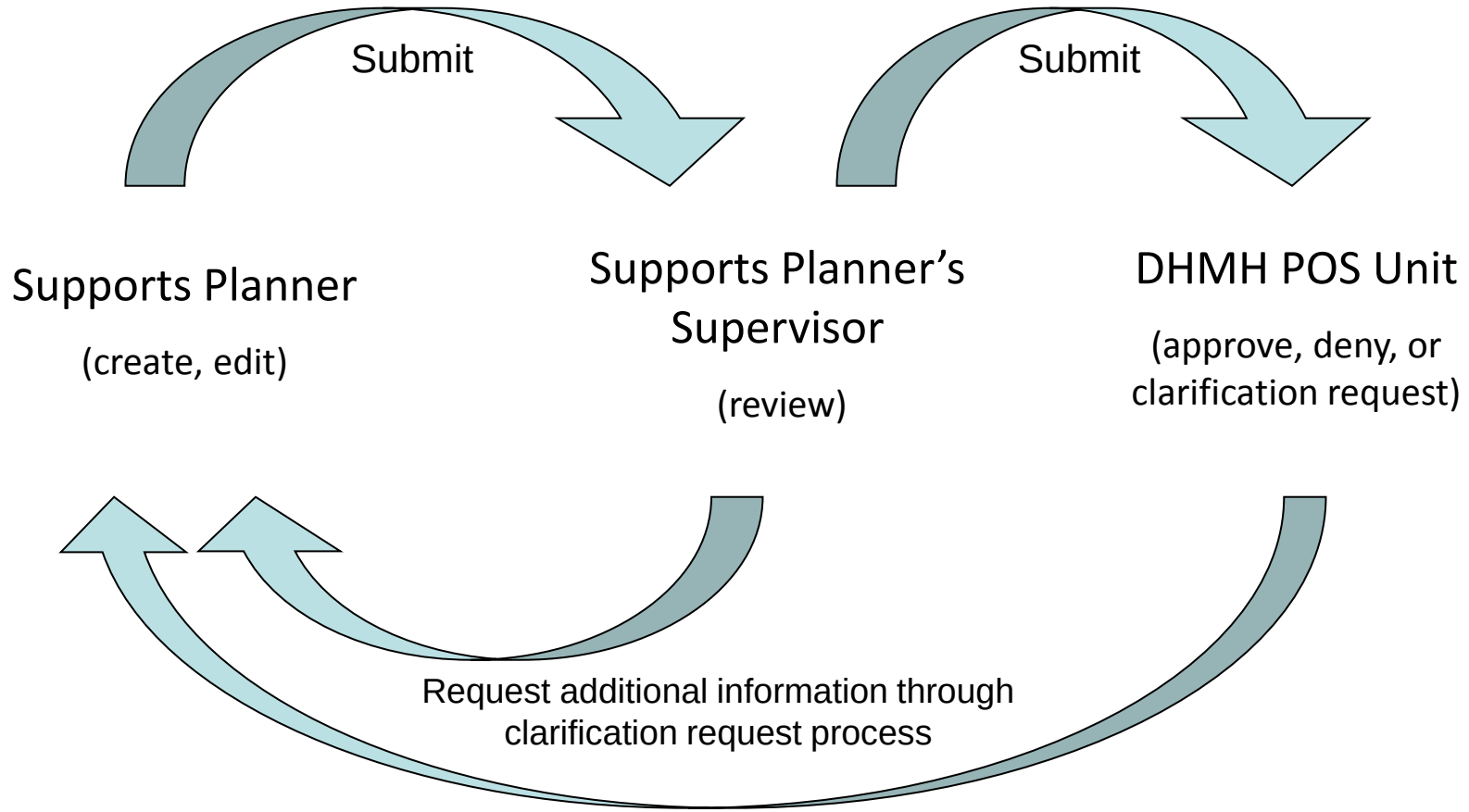
When is a Provisional Plan Ready to Submit?

- Are all the services listed on the plan?
  - Is each service supported by documentation?
- Are all recommended Plan of Care services addressed?
  - Either included in the services section or “declined” by applicant/participant in the overview narrative
- Is an emergency back-up listed?
- If necessary, is the exceptions form completed?
- Is the person eligible to receive Medicaid services?
  - For waiver participants, they must have LTC MA.
  - For CFC and CPAS participants, they must have Community MA.

When is an Initial or Annual Plan Ready to Submit?

- Are all the providers on the plan?
- Are the required signatures collected?
  - Nurse Monitor
  - Supports Planner
  - Emergency Back-up
  - Personal Assistance Agency (if applicable)
  - Other signatures may be collected after a plan is approved.
- Is the person eligible to receive Medicaid services?
  - For waiver participants, they must have LTC MA.
  - For CFC and CPAS participants, they must have Community MA.
- The LTSSMaryland system will display many of the requirements and if they are completed.

What Happens After I hit "Submit"?



Getting Approved

- After hitting submit, your supervisor reviews the plan.
  - They may request additional information if they believe something needs clarification or if something is missing.
- If it meets program and policy requirements, your supervisor then submits your plan to DHMH Plan of Service (POS) Unit.
- The DHMH POS Unit reviews the plan.
  - They review each service for medical necessity.
  - They use the InterRAI and recommended Plan of Care to confirm services are medically necessary. If questions arise, they will contact you or request additional information. The process will start again.
- When the plan is approved, you will be alerted in the LTSSMaryland system.

Urgent Requests

- All requests for urgent POS review must go to the POS Unit email account: dhmh.posunit@maryland.gov
- The email should identify the Client ID and the reason for the expedited review
- Examples of urgent revisions which should be sent to the POS box include:
  - A change in provider based on a Reportable Event (provider quit, was fired, was negligent, etc.)
  - Involuntary discharge from an institution
  - Hospital discharge
- Examples that should not be sent to the POS box as urgent:
  - Routine nursing facility discharges
  - Checking the status on a previously submitted plan
  - Plans not submitted timely

What are Some Potential Reasons for Denying a Plan?

- A participant may choose to request services that may not be allowed by the program.
  - They have the right to submit the plan they want.
  - There is a balance between guiding a participant to a person-centered but medically-based plan and supporting them in their request.
- A plan may be outside the scope of what the Department can determine medically necessary using documentation available.
  - The plan may be requesting more services than other participants with similar needs, or
  - The services available in the programs are not enough to keep a person healthy and safe in their current setting.

What Happens if a Plan is Denied?

- All participants are given appeal rights for a denial.
  - Instructions on how to appeal are sent to the participant.
    - Summary of Fair Hearings Procedures
  - The Office of Administrative Hearings will schedule a hearing to consider the request.
  - If it is an annual plan and the person does not have an active plan of service, services will stop 10 days from the date of the notice.
    - The participant may appeal within those 10 days to continue services however if they lose the judgment, they may be held liable for the cost of those services.
    - If they do not wish to appeal, the SP should create another plan with services indicated on the denial letter
      - Updated client signature is required

What Happens After POS Approval?

- The supports planner will get an alert that the plan of service was approved.
- The supports planner should check the following:
  - Medical eligibility is met
  - Technical criteria are met
  - Financial criteria are met
  - Medicaid eligibility is valid (coverage group and span)
- If the applicant has met all criteria, the supports planner must submit an Authorization to Participate (ATP) form in the LTSSMaryland system.

Do Not Initiate Services Prior to Enrollment

- Supports planning agencies are liable for services they initiate without following policies and procedures and failing to ensure participant and provider enrollment is complete and approved by DHMH.
- Starting services without verification of eligibility puts all involved at risk.
  - The provider may not get paid.
  - The participant may not be eligible and could lose eligibility status.
  - Services may never be reimbursable if participant never enrolls.

Service Notification Form

- The Community Options Service Notification Form for personal assistance should be completed upon personal assistance service initiation, revision or termination.
- The date that the form is sent to the personal assistance provider agency should be listed on the form, along with the date that the service initiation, revision or termination should take place.
- If the form is to notify the personal assistance provider agency of an initiation or a revision of services, a copy of the approved plan of service should be attached.
- If the form is to notify the personal assistance provider of a temporary revision of services, this should be noted on the form along with the date those temporary services should end.

Community Options Service Notification Form

This form serves as a notification of a change in your participant's services. Please review all information and proceed accordingly based on the service action. Questions should be directed to the participant's Supports Planner listed below.

Participant Information

Date:	
Participant:	
MA#:	
Program:	---
Provider:	
Service Type:	

Description

Service Action:	---
Effective Date:	
Temporary Authorization:	
Temp. Auth. End Date:	
Plan of Service Attached:	
Comments:	

Support Planner Contact Information

Supports Planner:	
Supports Planning Agency:	
Telephone Number:	
Email:	